

Ministry of Children and Family Development

Child Fatality Case Review Summary Report - 2001

A. Introduction

The purpose of case reviews is to promote excellence in case practice, confirm and recognize positive case practice, support high quality service delivery to children and families, and to ensure compliance with the standards, policy and the legislative mandate under the *Child, Family and Community Service Act (CFCSA)*.

Case reviews are undertaken following a serious occurrence to a child. The decision to conduct a case review is made as soon as possible and no later than 20 days following the occurrence. There are two types of case reviews, with different methodologies: deputy director's review and director's case review.

During 2001, 25 case reviews were completed. These included 22 deputy director's reviews (DDRs) and 3 director's case reviews (DCRs).

B. Deputy Director's Reviews (DDR)

DDRs are limited in scope and usually consist of a file review and generally focus on the last five years of service involvement. Following a decision to conduct a DDR, the review process includes an examination of relevant case files that results in a chronology and analysis/discussion of the information. There are no findings for this type of review. A DDR is expected to be completed as soon as possible and within 90 days of the decision to begin the review. A DDR can assist the Director in determining whether a DCR is required.

Summary of 22 DDRs completed in 2001

- 4 involved children in care, one child was Aboriginal
- The categories of death were suicide (1), natural (3)

- 18 involved children who were not in care when they died but who had received services from the Ministry within the past 12 months, 4 children were Aboriginal
- The categories of death were accidental (9), suicide (3), natural (4), undetermined (2)

C. Director's Case Reviews (DCR)

DCRs are comprehensive reviews that involve the examination of case files as well as interviews of relevant staff, caregivers and service providers. The decision to conduct a DCR is based on the severity of the occurrence, the potential link between case practice and the outcome for the child and the level of response required for public accountability. Following a decision to conduct a DCR, terms of reference are developed that define the scope of the review and confirm the processes of the review. A DCR is expected to be completed within 8 months of the decision to begin the review.

Summary of 3 DCRs completed in 2001

- 1 involved a child in care who was not Aboriginal
- The category of death was accidental

- 2 involved children who were not in care when they died but who had received services from the Ministry within the past 12 months, neither children were Aboriginal
- The categories of death were undetermined (1) and homicide (1)

D. Summary of Intakes from the Case Reviews

When a social worker receives a report of child abuse or a request for support services, the social worker must assess the information and register it on the electronic case management system as an intake. After the assessment, the social worker may offer support services to the child and family, refer the child and family to a community agency, or investigate the child's need for protection.

- The total number of intakes for the 25 case reviews was 89
- 45 of the intakes were assessed as requiring a child protection response involving an investigation of the child's need for protection
- 44 of the intakes were assessed as requiring a non-protective response such as offering support services to the child and family, referring the child and family to a community agency or taking no action

E. Summary of Findings/Analysis from the Case Reviews

Case reviews involve an analysis of case information in terms of case practice, service delivery and compliance with standards, policy and legislation.

Within the reviews completed in 2001, there were many examples of practice that met or exceeded standards.

Examples of best practice included:

- detailed comprehensive risk assessments
- consistent efforts were made to involve the Aboriginal community
- intakes were accurately assessed as protection reports
- well documented plans of care, that addressed the child's Aboriginal heritage, were completed and
- safety planning was comprehensive

In addition, case reviews completed in 2001 identified areas where service delivery could be improved. For the purpose of this report these have been organized into themes of case practice, organizational issues and inter-agency collaboration.

Case practice

- determining appropriate responses to reports
- conducting thorough child protection investigations
- conducting thorough risk assessments, including re-assessments of risk
- meeting guardianship responsibilities for children in care and
- utilizing an integrated case management approach when relevant

Organizational issues

- staffing levels and workload
- documentation
- availability of placement resources
- transferring files between offices
- providing support services in non-protective cases
- evaluating contracted service providers

Inter-agency collaboration

- information sharing
- integration amongst service providers
- accessing mental health assessments in urgent cases

F. Summary of Recommendations from the Case Reviews

Case reviews often result in the development of recommendations to address any areas where service delivery could be improved. These recommendations are tracked and monitored for implementation.

The total number of recommendations within the 25 case reviews completed in 2001 is 73. The recommendations focused on four themes: sharing of information; reviewing information and training; file documentation; and administration.

Sharing and debriefing the report with involved staff was a recommendation made consistently. In addition, recommendations to share the report with other program areas such as mental health and youth justice and other jurisdictions were also made.

With respect to reviewing information and training, recommendations focused on:

- reviewing practice standards pertaining to investigation, risk assessment, guardianship, and supervisory responsibilities
- providing training on integrated case management, suicide prevention, working with high risk youth and chronic neglect

With respect to file documentation, recommendations focused on:

- improving documentation of the investigation of reports

From an administrative perspective, recommendations focused on:

- developing standards for contracted agencies

- improved contracting processes
- developing policy for youth placements
- accessing mental health consultation
- creating additional supervisory positions
- developing and revising protocols with Aboriginal agencies
- examining child welfare service delivery models
- improving regional file transfer processes including ensuring that all file documentation is completed